

Cost Sharing Options

Submitted to the Joint Legislative Budget Committee
Phyllis Biedess, AHCCCS Director
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BACKGROUND

The Arizona Health Care Cost Containment System (AHCCCS) is required to report to the Joint Legislative Budget Committee (JLBC) on the savings that could be achieved in programs if application fees and other cost sharing measures are implemented. Laws 2002, Chapter 357, requires the report to discuss:

- 1) Savings associated with each option broken out by program, and
- 2) Administrative costs associated with implementing each option.

Guiding Principles

In preparing this report, AHCCCS used the following guiding principles.

- If allowable by federal law, AHCCCS eligible persons will have some form of cost sharing.
- Lower income populations will have lower cost sharing amounts.
- Impact on the provider community must be considered.
- Cost sharing will be implemented in the most efficient way to reduce administrative costs.
- Data will drive the conclusions.
- Any additional funds that are collected must be shared with the federal government at the Arizona FMAP rate.

Terms Used Throughout Document

- **ALTCS** - Arizona Long Term Care System - The AHCCCS program that provides long term care services to the elderly and physically or developmentally disabled persons.
- **CMS** - Centers for Medicare and Medicaid Services - The federal agency that regulates Medicaid.
- **Expansion population** - Persons added because of voter approval of Proposition 204 with income up to 100% of FPL.
- **HIFA** - A federal initiative that enabled Arizona to cover the parents of KidsCare children with 75% federal funding.
- **KidsCare children** - A program to cover children up to the age of 19 with household income up to 200% of FPL.

- **Traditional Medicaid** - Individuals who are aged, blind or disabled, a pregnant woman or children who have lower incomes than the Expansion population.

FINDINGS

AHCCCS reviewed federal law and regulations, practices in other states and waiver possibilities to determine the feasibility of requiring higher copayments, premiums and other cost sharing strategies for Traditional Medicaid, KidsCare children, HIFA parents and Expansion enrollees. Federal law and regulations are very clear that copayments must be nominal for Traditional Medicaid enrollees and must be waived if a person can not pay. Copayments amounts can be higher for Expansion populations. Considering these parameters, the state could request CMS approval for the following changes to current cost sharing requirements:

- Add new copayments and increase others through a waiver approved by CMS - this change will not increase revenue to the General Fund for the reasons explained below.
- Increase the monthly premium for KidsCare children and include a monthly premium for the new HIFA Parents.
- Request federal approval to collect monthly premiums for children enrolled in ALTCS. The estimates are based on a 5% premium for households with income above 221% of FPL. This threshold was chosen because it approximates the current eligibility level of 300% of SSI for the ALTCS program.
- Request waiver approval to impose an initial enrollment fee for KidsCare children, HIFA Parents and the Expansion population that must be paid before an applicant is enrolled with AHCCCS.

COPAYMENTS

The current copayment amounts are described in Appendices 1 and 2. Copayments are fixed amounts that are collected by providers, such as physicians or laboratories, at the time a service is rendered. In turn, the health plans or program contractors reduce reimbursement to these contracted providers to reflect the dollar amounts that are collected by the provider. Even at the nominal levels, the experience in Arizona and other states is that only about 2% of the possible copayments are collected from Traditional Medicaid populations since the copayment must be waived if the person can not afford to pay.

For the purposes of this report, AHCCCS used a 2% collection rate (25% for prescriptions) for the Traditional Medicaid population and a threshold of 50% and 75% as the collection rate for KidsCare children, HIFA parents and the Expansion population. If providers collect copayments at this level, the revenue that will be generated is between \$7,003,000 and \$10,247,000. However, increasing the copayments is not a direct fiscal benefit to the state since AHCCCS does not collect the copayments. Revenue that is generated by new or increased copayments will be considered as part of the actuarial analysis of capitation rates and could result in smaller capitation rate increases in the future.

Federal law is very specific about the amount of copayments and sets the following parameters:

- 1) Copayments must be nominal and waived for traditional Medicaid members who can not afford to pay.

- 2)** No copayments can be imposed on:
- Family planning (Medicaid).
 - Services received by children under 18 years of age, pregnant women, individuals receiving hospice care and institutionalized individuals (Medicaid).
 - Well baby and well-child services (KidsCare).
 - Routine preventive and diagnostic services (KidsCare).
- 3)** Unless a waiver is granted by CMS, the maximum copayment is \$3 for traditional Medicaid recipients.
- 4)** SCHIP limits the amount of out-of-pocket expenses for copayments and monthly premiums to no more than five percent of the household income of KidsCare children and HIFA parents.
- 5)** CMS will consider higher copayments on Expansion populations such as the Proposition 204 groups and HIFA parents.
- 6)** States are required to return the federal share (FMAP) portion of the copayments to the federal government which reduces the amount of revenue that could be realized from new or increased copayments.

Considering the federal requirements, CMS guidance and the experience in other states, the state could add or increase copayments as reflected in Table 1. In order for the state to generate revenue that merits an increase in copayments, it is essential that CMS allow the state to refuse a Medicaid service for KidsCare children and HIFA parents and Expansion populations if the copayment is not paid. To date, CMS has not approved any state's request to deny services if the Medicaid recipients can not afford to pay. If the request is not approved by CMS, physicians, hospitals and other providers must provide services and will be penalized if the state lowers reimbursement to account for copayments that can not be collected. Other waivers will be needed to increase copayments for the non-emergency use of the emergency room and for non-emergency transportation. CMS has not approved higher copayments for Traditional Medicaid populations but have approved a few waiver requests to increase copayments on Expansion populations.

Table 1-State Share of Revenue to Providers Due to Increased or Added Copayments (Does not include behavioral health and the RHBAs)

Program	Generic Prescriptions \$2 Traditional Medicaid \$5 All Others	Brand Name Prescriptions \$2 Traditional Medicaid \$8 Expansion and HIFA \$5 KidsCare	Non-Emergency Use of the Emergency Room \$6 Traditional Medicaid \$10 KidsCare <150% \$30 All Others	Non-Emergency Transportation \$5 Traditional Medicaid and KidsCare <150% \$10 All Others	All Other Services \$2 Traditional Medicaid \$5 All Others
Traditional Medicaid (1)	\$322,000	\$132,000	Negligible for this group since hospitals must stabilize an "emergency" and waive the copayment if the person can not pay	\$8,000	\$12,000 (Primary Dr.) \$22,000 (Specialist) \$3,000 (Lab and X-ray)
Prop 204 Expansion Groups (2)	\$1,383,000-\$2,074,000	\$904,000-\$1,355,000	\$31,000-\$46,000	\$338,000-\$507,000	\$1,903,000-\$2,854,000 (Primary Dr.) \$589,000-\$884,000 (Specialist) \$881,000-\$1,321,000 (Lab and X-ray)
HIFA Parents (2)	\$83,000-\$125,000	\$55,000-\$82,000	\$3,000-\$4,000	\$15,000-\$22,000	\$118,000-\$177,000 (Primary Dr.) \$27,000-\$40,000 (Specialist) \$36,000-\$54,000 (Lab and X-ray)
KidsCare <150% of the FPL (2)	\$29,000-\$44,000	\$12,000-\$18,000	Negligible	\$4,000-\$5,000	\$0 (3) (Primary Dr.) \$9,000-\$13,000 (Specialist) \$20,000-\$30,000 (Lab and X-ray)
KidsCare >150% of the FPL (2)	\$24,000-\$35,000	\$10,000-\$14,000	\$1,000	\$6,000-\$9,000	\$0 (3) (Primary Dr.) \$7,000-\$10,000 (Specialist) \$16,000-\$24,000 (Lab and X-ray)
GRAND TOTAL	\$1,841,000-\$2,600,000	\$1,113,000-\$1,601,000	\$35,000-\$51,000	\$371,000-\$551,000	\$3,643,000-\$5,444,000

1. Traditional Medicaid estimates are based on collecting 2% of the copayments (25% for prescriptions) since a state can not deny services if the person can not pay.

2. KidsCare, HIFA and Expansion Populations estimates are based on collecting a range of 50% and 75% of the copayments. This percentage is dependent on getting CMS approval to deny services if the copayment is not paid.
3. There is no data on primary doctor copayments for KidsCare since copayments can not be assessed on well baby or well child visits.
4. Enrollment information as of 7/1/02
5. This is a snapshot of the data. Utilization and enrollment may change over time and increase or decrease the collections.

Administrative Costs

There will be new administrative costs at the health plan or program contractor level to pay providers to collect these copayments.

MONTHLY PREMIUMS

Premiums are monthly amounts a member pays to maintain enrollment in AHCCCS. The federal limitations are:

- 1) States can not charge a monthly premium on Traditional Medicaid populations.
- 2) There is some flexibility to assess a monthly premium on Expansion populations with approval by CMS.
- 3) AHCCCS may impose a premium for KidsCare children and HIFA parents but the combined total of all cost sharing can be not more than five percent of the household income.
- 4) States are required to return the federal share (FMAP) portion of the premium to the federal government which reduces the amount of revenue that the state may realize.

Monthly Premiums for KidsCare and HIFA Parents

As shown in Table 2, the state may assess a monthly premiums on HIFA Parents, impose a monthly premium for KidsCare children under 150% of the FPL and increase the monthly premium by \$5 for all other KidsCare children between 150% to 200% of the FPL.

The estimated revenue is calculated based on 100% payment of the premiums since the premium must be paid in order to continue participation in the program.

Table 2-Increased Premium Amounts Based on 100% Collection (State Share Only)

Premiums/per month	100% to 150% FPL	150% to 175% FPL	175% to 200%FPL
KidsCare	\$15 for one KidsCare child	\$20 for one KidsCare child	\$25 for a household with one KidsCare child
	\$25 for more than one KidsCare child	\$30 for more than one KidsCare child	\$35 for more than one KidsCare child
	\$1,312,000	\$472,000	\$346,000
Premiums/per month	100% to 150% FPL	150% to 175% FPL	175% to 200%FPL
HIFA Parents	\$15 for each HIFA parent	\$20 for each HIFA parent	\$25 for each HIFA parent
	\$1,348,000	\$225,000	\$205,000
	GRAND TOTAL		\$3,908,000

Administrative Costs

AHCCCS currently collects premiums for the KidsCare Program. Administrative costs to increase the premiums can be absorbed by the agency.

Assess Monthly Premiums on Households With ALTCS Eligible Children

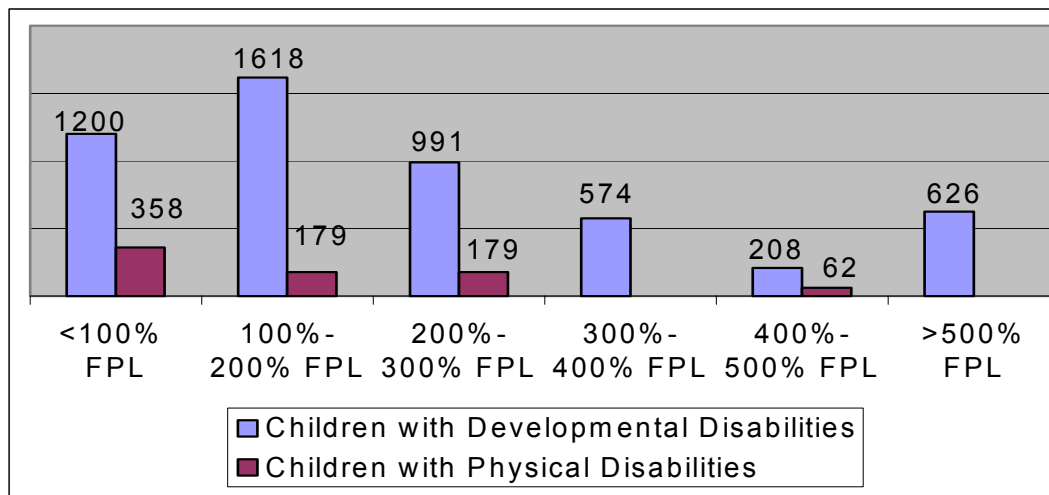
Currently, parental income is not counted when a child under the age of 18 applies for enrollment in ALTCS. In 1987, the state decided not to count parental income in order to cover as many disabled children as possible with federal funds and to reduce the waiting list for services provided to children with developmental disabilities.

There are almost 6,000 physically or developmentally disabled children enrolled in ALTCS who live at home with parents with household income levels that range from under 100% of the FPL to well over 1500% of the FPL (see Table 3). Even at the higher income levels, parents do not pay anything toward the cost of ALTCS services for their children.

The state could pursue a waiver from CMS that would allow the state to assess a monthly premium based on household income above 221% of the FPL for children enrolled in ALTCS. This FPL level approximates the current eligibility level of 300% of SSI that is used to determine financial eligibility for the ALTCS program. This FPL also targets households with higher income (e.g. a family of four with a monthly income of over \$3,333).

CMS has advised the state that any change in the long term care program will require the state to negotiate a budget neutrality agreement for ALTCS, which will increase administrative costs to the agency for this task. If the state receives approval, rules must be promulgated to support the amount of the premiums.

Table 3- Households by Income Levels (Revised November 22, 2002)



An example of the amount of the monthly premium based on household income is depicted in Table 4.

Table 4-ALTCS Monthly Premiums (State Share Only)

5% of Household Income	Premium Amount	Estimated Total Revenue
Income from 221%-300% of FPL	\$138	\$410,000
Income above 300%-400% of FPL	\$187	\$416,000
Income above 400%-500 of FPL	\$250	\$263,000
Income above 500% of FPL	\$312	\$757,000
GRAND TOTAL		\$1,846,000

1. The ALTCS estimation was based on a sample size of 305 children under the age of 18 who reside at home with a parent.
2. The dollar figure represents a household of 3.

Enrollment Fees

Utah received CMS' approval to impose an enrollment fee on Expansion populations at the time of initial enrollment. The state could request a waiver from CMS to impose a \$25 enrollment fee at the time of initial enrollment. AHCCCS has estimated the revenue that would be generated by this new fee in Table 5 but can not quantify the impact to the AHCCCS' budget if healthy people do not enroll until they are sick or what the amount of the increase in uncompensated care for hospitals and providers will be.

Table 5-Add a \$25 Enrollment Fee at 100% Collection (State Share Only)

\$25 Enrollment Fee	Increased Revenue
Prop 204 Expansion Groups	\$595,000
HIFA Parents	\$182,000
KidsCare Children	\$483,000
TOTAL	\$1,260,000

NECESSARY ACTIONS TO IMPLEMENT COST SHARING CHANGES

In order to increase or add copayments, enrollment fees and monthly premiums the legislature must amend AHCCCS' statutes and CMS must approve a waiver before the state could:

- Set copayment amounts above the "nominal" standard in federal and state law.
- Deny a service if a member refuses to pay the copayment.
- Add enrollment fees and increase or add new premiums.

ENHANCED REVENUE

Table 6 provides a total estimate of potential offset for higher copayments and new revenue that may be generated by new or higher premiums. These estimates are based on several variables including state and federal approval, enrollment numbers at today's levels or higher and the willingness of the providers to collect copayments.

Any budget estimate must take into account that copayments will not increase revenue to the state in the short term. The long term benefit to the state will depend on whether the amount of copayments that are collected by the providers is sufficient to warrant a future offset to the overall medical inflation cost that is factored into capitation rates to keep them actuarially sound.

Table 6-Estimated Collection of Higher and New Copayments

Source	Total Revenue	Federal Share	State Share	Statute Change	Waiver Request
Add Generic Prescription Copayment (1) <ul style="list-style-type: none"> • \$2 Traditional Medicaid • \$5 All Others 	\$5,801,000-\$8,209,000	\$3,959,000-\$5,608,000	\$1,841,000-\$2,600,000	Yes	No
Add Brand Name Prescription Copayment (1) <ul style="list-style-type: none"> • \$2 Traditional Medicaid • \$5 KidsCare Children • \$8 Expansion and HIFA 	\$3,494,000-\$5,039,000	\$2,381,000-\$3,438,000	\$1,113,000-\$1,601,000	Yes	No
Increase Copayments for the Non-Emergency Use of the ER (2) <ul style="list-style-type: none"> • \$6 Traditional Medicaid • \$10 KidsCare Children <150% • \$30 Expansion, HIFA, and KidsCare Children >150% 	\$111,000-\$164,000	\$76,000-\$112,000	\$35,000-\$51,000	Yes	Yes
Add Copayment for Non-Emergency Transportation (2) <ul style="list-style-type: none"> • \$5 Traditional Medicaid and KidsCare Children <150% • \$10 Expansion, HIFA and KidsCare Children >150% 	\$1,162,000-\$1,730,000	\$791,000-\$1,179,000	\$371,000-\$551,000	Yes	Yes
Increase/Add Copayment for Primary Doctor (2) <ul style="list-style-type: none"> • \$2 Traditional Medicaid • \$5 All Others 	\$6,362,000-\$9,524,000	\$4,329,000-\$6,481,000	\$2,033,000-\$3,043,000	Yes	Yes
Increase/Add Copayment for Specialist (2) <ul style="list-style-type: none"> • \$2 Traditional Medicaid • \$5 All Others 	\$2,053,000-\$3,045,000	\$1,398,000-\$2,075,000	\$654,000-\$969,000	Yes	Yes
Increase/Add Copayment for Lab and X-ray (2) <ul style="list-style-type: none"> • \$2 Traditional Medicaid • \$5 All Others 	\$3,016,000-\$4,517,000	\$2,058,000-\$3,084,000	\$956,000-\$1,432,000	Yes	Yes
Total Copayments	\$21,999,000-\$32,228,000	\$14,992,000-\$21,977,000	\$7,003,000-\$10,247,000		

Over a 12-month period, premiums could generate new revenue to the state if CMS approves the waiver.

Table 7 - New or Higher Premiums

Source	Total Revenue	Federal Share	State Share	Statute Change	Waiver Request
Premiums for HIFA Parents and KidsCare Children	\$17,050,000	\$13,142,000	\$3,908,000	Yes	Yes
Premiums for ALTCS	\$5,638,000	\$3,792,000	\$1,846,000	Yes	Yes
Enrollment Fees	\$4,720,000	\$3,460,000	\$1,260,000	Yes	Yes
Total Premium Collections	\$27,408,000	\$20,394,000	\$7,014,000		

GRAND TOTAL	\$49,407,000- \$59,636,000	\$35,386,000- \$42,371,000	\$14,017,000- \$17,261,000
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1. Traditional Medicaid estimates are based on collecting 2% of the copayments (25% for prescriptions) since a state can not deny services if the person can not pay.
2. KidsCare, HIFA and Expansion populations estimates are based on collecting range of 50% and 75% of the copayments. This percentage is dependent on getting CMS approval to deny services if the copayment is not paid.
3. Amounts of individual sharing options were rounded. Due to this rounding, amounts shown as totals, federal or state share may not reconcile to exact figures.

Appendix 1

AHCCCS Current Copayments

Traditional Medicaid

Service	Copayment
Non-emergency use of the emergency room	\$5
Non-emergency surgery procedure	\$5
Doctor's office or home visit and all diagnostic and rehabilitative x-ray and laboratory services associated with the visit	\$1

KidsCare Children

Service	Copayment
Non-emergency use of the emergency room	\$5

Appendix 2

Federal Copayment Limits

Traditional Medicaid

Copayments can range from \$0.50 to \$3 depending on the cost of the service.

Cost of Service	Copayment
0-\$10	\$0.50
\$10.01-\$25	\$1
\$25.01-\$50	\$2
\$50.01 and higher	\$3

*Non-emergency use of the emergency room can be increased from \$5 to \$6 with a waiver.

Exclusions

Copayments may not be charged on:

- Family planning; and
- Services received by children under 18 years of age, pregnant women, individuals receiving hospice care and institutionalized individuals.

KidsCare Children

For KidsCare children under 150% of the FPL, non-emergency use of the emergency room copayments cannot exceed \$10 and copayments on all other services cannot exceed \$5. Total cost sharing (copayments, premiums, and enrollment fees) cannot exceed 5% of the household annual income.

Total Out of Pocket @ 5% Cap

Family Size	5% of 100% FPL	5% of 150% FPL	5% of 175% FPL	5% of 200% FPL
1	443.00	664.50	775.25	886.00
2	597.00	895.50	1,044.75	1,194.00
3	751.00	1,126.50	1,314.25	1,502.00
4	905.00	1,357.50	1,583.75	1,810.00

Exclusions

Copayments may not be charged on:

- Well baby and well-child services, and
- Routine preventive and diagnostic services.